MARIN COUNTY
OFFICE OF EDUCATION

Confidential Pupil Record

AUTHORIZATION TO ADMINISTER MEDICATION DURING THE SCHOOL DAY

School Year: _____

Student Name:		Date of Birth:		Grade / Class:	
School:		Parent/Guardian:		Phone:	

In accordance with California Education Code section 49423, this form must be on file for any student who requires medication(s) during the regular school day.

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a])

A. Other information relevant to the administration of the medication: _____

B.

Name of Medication	**Route (oral, inhaled, etc)**	**Dosage**	**Time (or Freq. if PRN)**	**Indications if PRN**	**Discontinue Date**
1.					
2.					
3.					

C. Please indicate if this student has permission to carry emergency medication:

☐ Yes – This student has permission to carry and self-administer the following emergency medication(s): _____

☐ No – This student may not carry and self-administer any emergency medication. The medication must be kept and/or carried by a responsible adult at all times.

D.

Provider Signature:		Date:		Phone:	
Provider Name:		NPI:		Fax:	

Stamp:

E. Upon receipt of medication orders, the school nurse and the prescribing health care provider shall consult as needed.

a. A current medication form must be on file. A new form must be on file each school year.
b. Changes to prescribed dose and/or other details of medication administration require a new authorization form.
c. All medication must be in the original container and all prescription medication must have an affixed pharmacy label that includes the student's name.
d. An adult must bring the medication to the school and pick up any outdated or unused medication. Medication not picked up on the last school day will be discarded.
e. Parents/Guardians must provide all materials or necessary equipment for medication administration.

F.

I authorize the school nurse, or other designated school personnel, to administer the medication as directed by the authorized health care provider. I understand that designated school staff have my permission to communicate with the prescribing physician/health care provider on matters related to this medication.

Parent/Guardian Signature:		Date:		Parent/Guardian Name:		Phone:	
Nurse Signature:		Date:		Comments:			